

# Wisconsin Department of Safety and Professional Services

Mail To: P.O. Box 8935  
Madison, WI 53708-8935

FAX #: (608) 261-7083

Phone #: (608) 266-2112

1400 E. Washington Avenue  
Madison, WI 53703

E-Mail: web@dsps.wi.gov

Website: http://dsps.wi.gov

## MASSAGE THERAPY AND BODYWORK THERAPY AFFILIATED CREDENTIALING BOARD

### APPLICATION FOR MASSAGE THERAPIST OR BODYWORK THERAPIST

Under Wisconsin law, the Department must deny your application if you are liable for delinquent state taxes or child support (sec. 440.12, Stats.).

**PLEASE TYPE OR PRINT IN INK**

☐

Your name and address are available to the public.

Check box to withhold street address/PO Box number from lists of 10 or more credential holders (Wis. Stat. § 440.14)

Last Name

First Name

MI

Former / Maiden Name(s)

Your Street Address (number, street, city, state, zip)

Mail To Address (if different)

Date of Birth

Daytime Telephone Number

month

day

year

( ) -

Ethnic/gender status  
information is optional.

Sex:

☐ M

☐ F

Ethnic:

☐ White, not of Hispanic origin

☐ Black, not of Hispanic origin

☐ Hispanic

☐ American Indian or Alaskan

☐ Asian or Pacific Islander

☐ Other

Have you ever held a license/credential in the state of Wisconsin?

Yes No (please indicate)

If yes, provide your Wisconsin license/credential number.

The certificate expires on March 1 of the odd-numbered year. It may be renewed for a two year period at that time.

#### MASSAGE THERAPY OR BODYWORK THERAPY COURSEWORK:

School Name:

(City / State)

Date Completed:

#### HIGH SCHOOL / GED:

School Name:

(City / State)

Date Completed:

**APPLICATION FEES: Make check payable to DSPS for the total DSPS fee and attach to this application.**

Check appropriate box

- ☐ **LICENSURE BY EXAMINATION** (Applicants who have passed or plan to take a nationally administered entry-level competency assessment examination that meets generally accepted psychometric principles and standards.)

\$ 75.00 State Law Exam

\$ 75.00 Credential fee

\$ 150.00 DSPS Total fee attached

**Request for a Temporary License** (Is required in addition to the above DSPS Total Fee and is non-refundable.)

- ☐ \$ 10.00 This provision only applies to those eligible for licensure by examination and who have met all other requirements for licensure, but who have not yet received scores from an approved nationally-administered entry-level competency assessment examination.

- ☐ **LICENSURE BY RECIPROCITY**

(Applicants who have a similar license or credential issued by another state or territory of the United States or another country that is substantially equivalent.)

\$ 75.00 State Law Exam

\$ 82.00 Credential fee

\$ 157.00 DSPS Total fee attached

#### For Receiving Use Only

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**YOU MUST CHECK THE SECTION UNDER WHICH YOU ARE SEEKING LICENSURE.** Under each section is a list of documents required for licensure. Your application will not be considered complete until all of these documents have been received by the Department. *Is name on all documents the same? If not, submit a certified copy of marriage certificate, divorce decree, etc.*

☐ **EXAMINATION:** (Applicant has passed a nationally administered entry-level competency assessment examination that meets generally accepted psychometric principles and standards.)

- Submit a signed copy (front and back) of current CPR/AED certificate from a DHS approved provider. For a listing of approved providers go to [http://www.dhs.wisconsin.gov/ems/License\\_certification/CPR.htm](http://www.dhs.wisconsin.gov/ems/License_certification/CPR.htm).
- Completed signed and notarized application (Form #2960)
- Fee attached to this application
- Wisconsin State Law Examination: The Wisconsin Massage Therapy and Bodywork Therapy State Law Exam is an on-line open book examination on the Wisconsin Statutes and Administrative Codes that govern massage therapists and bodywork therapists. Each massage therapy or bodywork therapy school will notify the students when and where to complete the examination; it is recommended that the applicant complete the examination as soon as reasonable. Candidates will be assigned an ID#, test name and password after submitting an application. If you graduated from massage therapy or body work therapy school prior to 1/1/2012 or graduated from a school in another state, you will be given information to take the exam after your application is received at DSPS. If you fail this examination, a retake examination fee will be required.

The exam may be accessed from any PC by using Internet Explorer. The testing system will not work on a MAC computer or any web browser other than Internet Explorer.

INSERT INSTRUCTION HERE

**IMPORTANT:** Upon completion of the exam, the applicant will be presented with the option to “Print test feedback report”. The applicant **MUST** choose this option (“Print test feedback report”) to have the examination score available for review. **DSPS does NOT have the ability to recall a score. If the applicant fails to print the test feedback report when given the option, the applicant will be required to retake the examination and pay an additional fee.**

- Massage Therapy or Bodywork Program Curriculum Form #2962 (This form must be forwarded and completed by your school and returned directly to the Department of Safety and Professional Services.)
- Copy of a certificate of malpractice liability insurance policy currently in effect which shows the applicant as a policyholder and insured, with coverage in an amount that is not less than \$1,000,000 per occurrence and \$1,000,000 for all occurrences in one year, and expiration dates.
- Evidence of having passed either the “National Certification Examination of the National Certification Board for Therapeutic Massage and Bodywork”, the “Asian Bodywork Therapy Exam” of the National Certification Commission for Acupuncture and Oriental Medicine, or Federation of State Massage Therapy Boards (FSMTB) Massage and Bodywork Licensing Examination (MBLEx). ***This evidence must come directly from the examination services listed above.*** See Form #2961 for further information.

☐ Request for Temporary license. (If you choose this option in addition to licensure by examination, you must meet all criteria listed on Form 2961.)

☐ **BY RECIPROCITY:**

- Completed and notarized application (Form #2960)
- Submit a signed copy (front and back) of current CPR/AED certificate from a DHS approved provider. For a listing of approved providers go to [http://www.dhs.wisconsin.gov/ems/License\\_certification/CPR.htm](http://www.dhs.wisconsin.gov/ems/License_certification/CPR.htm).
- Fee attached to this application

## Wisconsin Department of Safety and Professional Services

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- Copy of a certificate of a malpractice liability insurance policy currently in effect which shows the applicant as a policyholder and insured, with coverage in an amount that is not less than \$1,000,000 per occurrence and \$1,000,000 for all occurrences in one year and expiration dates.
- Verification of a current license, registration or certification issued by another state or territory of the United States or province of another country. You are required to have **each jurisdiction** in which you have ever been credentialed submit letters of verification directly to the Wisconsin Department of Safety and Professional Services. The letters must indicate your date of birth, credential number, date of issuance, and a statement regarding disciplinary actions. These letters will be required in order to complete your application for licensure. **City or county certification does not meet the licensure requirement.**
- Copy of the current law pertaining to licensure and practice of massage therapy or bodywork in effect in the states or jurisdictions in which you are credentialed. *(The information is used to determine if the requirements for a similar license, registration or certificate are substantially equivalent to the requirements under s. 460.05, Stats. The statutes and rules may be viewed at [dps.wi.gov](http://dps.wi.gov).)*

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**I AM, OR HAVE BEEN, LICENSED IN THE FOLLOWING STATES (Include all active and inactive states):**

By Written Exam: \_\_\_\_\_

By Endorsement/Reciprocity: \_\_\_\_\_

**\*Verification of each license you currently hold or have held is required in writing from every state licensing authority.**

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**PLEASE CHECK ONE FOR TEMPORARY LICENSE:**

\_\_\_\_\_ I plan to take the next National Certifying Examination on \_\_\_\_\_ month/day/year

\_\_\_\_\_ I have taken and passed the National Certifying Examination

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**ANSWER THE FOLLOWING QUESTIONS:** (Attach additional sheets if necessary.)

1. Have you graduated from high school or attained high school graduation equivalency?

**YES**

**NO**

☐☐

If yes, indicate - Name of High School \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Date of graduation \_\_\_\_\_

OR

Date high school graduation equivalency obtained \_\_\_\_\_

Granting agency \_\_\_\_\_

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	<u>YES</u>	<u>NO</u>
2. Are you familiar with the state health laws and rules and regulations of the Wisconsin Department of Health and Family Services regarding communicable diseases?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you <u>ever</u> failed to pass any state or national accrediting examination in the field of massage therapy or body work therapy, including but not limited to the NCBTMB exams, MBLEx, NCCAOM (this does not include examinations taken solely as part of a massage therapy and body work therapy education program)? If yes, give details on attached sheet.	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever surrendered, resigned, cancelled or been denied a professional license or other credential in Wisconsin or any other jurisdiction? If yes, give details on an attached sheet, including the name of the profession and the agency.	<input type="checkbox"/>	<input type="checkbox"/>
5. Has any governmental credentialing agency ever taken any disciplinary action against you, including but not limited to, any warning, reprimand, suspension, probation, limitation, revocation? If yes, provide details about the action, including the name of the credentialing agency and date of the action.	<input type="checkbox"/>	<input type="checkbox"/>
6. Is disciplinary action pending against you in any jurisdiction? If yes, attach a sheet providing details about pending action, including the name of the agency and status of action.	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have any felony or misdemeanor charges pending against you? If yes, submit Convictions and Pending Charges (Form #2252). Please do not give details on minor traffic charges, but do include information relating to Driving While Intoxicated (DWI) charges.	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever been convicted of a misdemeanor or a felony? If yes, submit Convictions and Pending Charges (Form #2252). Please do not give details on minor traffic convictions, but do include information relating to Driving While Intoxicated (DWI) charges.	<input type="checkbox"/>	<input type="checkbox"/>
9. Are you incarcerated, on probation or on parole for any conviction? If applicable, attach a sheet providing details including the terms of incarceration and a copy of a report from your probation or parole officer with the officer's contact information.	<input type="checkbox"/>	<input type="checkbox"/>
10. Have any law suits or claims ever been filed against you as a result of professional services? If yes, submit a certified copy of the claim or law suit and a copy of the final settlement or disposition.	<input type="checkbox"/>	<input type="checkbox"/>
11. Are you registered, licensed or certified in any other profession(s)? If yes, state what profession(s) and in what state(s).	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you ever been credentialed under any other name(s)? If yes, state name(s) credentialed under.	<input type="checkbox"/>	<input type="checkbox"/>

For the purposes of questions 11-17, the following phrases or words have the following meanings:

"Ability to practice massage therapy or bodywork therapy" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate assessment and exercise reasoned massage therapy or bodywork therapy judgments and to learn and keep abreast of massage therapy or bodywork developments; and
2. The ability to communicate those judgments and massage therapy or bodywork therapy information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform massage therapy or bodywork therapy tasks, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in the weeks or months preceding, the completion of this application. Rather, it means recently enough that the use of drugs may have an ongoing impact on one's functioning as a licensee, or **within the past two years**, whichever is longer.

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"Illegal use of controlled dangerous substances" means the use of controlled dangerous substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

	<u>YES</u>	<u>NO</u>
13. Do you have a medical condition which in any way impairs or limits your ability to practice massage therapy and bodywork therapy with reasonable skill and safety? If yes, please explain.	<input type="checkbox"/>	<input type="checkbox"/>
14. Does your use of chemical substance(s) in any way impair or limit your ability to practice massage therapy and bodywork therapy with reasonable skill and safety? If yes, please explain.	<input type="checkbox"/>	<input type="checkbox"/>
15. Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? If yes, please explain.	<input type="checkbox"/>	<input type="checkbox"/>
16. Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice? If yes, please explain.	<input type="checkbox"/>	<input type="checkbox"/>
17. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? If yes, please explain.	<input type="checkbox"/>	<input type="checkbox"/>
18. Are you currently engaged in the illegal use of controlled dangerous substances?	<input type="checkbox"/>	<input type="checkbox"/>
19. If yes, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? If yes, please explain.	<input type="checkbox"/>	<input type="checkbox"/>

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## ALL APPLICANTS MUST COMPLETE THIS SECTION

### CERTIFICATION OF LEGAL STATUS.

I declare under penalty of law that I am (check one):

\_\_\_\_\_ a citizen or national of the United States, or

\_\_\_\_\_ a qualified alien or nonimmigrant lawfully present in the United States who is eligible to receive this professional license or credential as defined in the Personal Responsibility and Work Opportunities Reconciliation Act of 1996, as codified in 8 U.S.C. §1601 et. seq. (PRWORA). For questions concerning PRWORA status, please contact the U.S. Citizenship and Immigration Services in the Department of Homeland Security at 1-800-375-5283 or online at <http://www.uscis.gov>.

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## AFFIDAVIT OF APPLICANT

(Sign and date in the presence of a notary)

I declare that I am the person referred to on this application and that all answers set forth are each and all strictly true in every respect. I understand that failure to provide requested information, making any materially false statement and/or giving any materially false information in connection with my application for a credential or for renewal or reinstatement of a credential may result in credential application processing delays; denial, revocation, suspension or limitation of my credential; or any combination thereof; or such other penalties as may be provided by law. I further understand that if I am issued a credential, or renewal or reinstatement thereof, failure to comply with the statutes and/or administrative code provisions of the licensing authority will be cause for disciplinary action.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

State of \_\_\_\_\_ County of \_\_\_\_\_

Subscribed and sworn to before this \_\_\_\_\_ day of

\_\_\_\_\_, 20\_\_\_\_, by \_\_\_\_\_  
(Applicant name)

\_\_\_\_\_  
Signature of Notary Public

**S E A L**

\_\_\_\_\_  
Date Commission Expires

# Wisconsin Department of Safety and Professional Services

**SOCIAL SECURITY NUMBER.** Your social security number (or employer identification number if you are applying as a business entity) must be submitted with your application on this form. If you do not have a social security number you must submit a statement under oath or affirmation. If your social security number or a statement is not provided, your application will be denied.<sup>1</sup> A form for submitting a statement that you do not have a social security number is available from the department.

**(Please Print)**

**First Name**

**Middle Initial**

**Last Name**

## Profession

Date of Birth

month

day

year

$$\begin{array}{|c|c|c|} \hline & & \\ \hline \end{array} - \begin{array}{|c|c|} \hline & \\ \hline \end{array} - \begin{array}{|c|c|c|c|} \hline & & & \\ \hline \end{array}$$

Social Security Number or FEIN

The Department may not disclose the social security number collected above except to the Department of Children and Families for purposes of administering the child and spousal support program,<sup>2</sup> to the Department of Revenue for the purpose of determining whether you are liable for delinquent taxes,<sup>3</sup> and to the federal Healthcare Integrity and Protection Data Bank for the purpose of reporting adverse actions against health care practitioners.<sup>4</sup>

**EMAIL ADDRESS:**

**Do you have an email address?**

☐ **Yes**

☐ **No**

**If yes**, this field is required to receive your application status electronically. Your email address must be clearly legible with the correct case sensitive information.

**EMAIL ADDRESS:** Submit your email address in the spaces provided below or attach a printer copy.

[illegible]

**If no,** your checklist will be sent by first class mail.

<sup>1</sup> Section 440.03 (11m), Wis. Stats.

<sup>2</sup> Sections 49.22, and 440.13, Wis. Stats.

<sup>3</sup> Section 440.12, Wis. Stats.

<sup>4</sup> Health Insurance Portability and Accountability Act (HIPAA) of 1996

This form is authorized by secs. 440.12 and 440.14, Wis. Stats. Making a false statement in connection with this application may result in revocation or denial.